FSM Podcast Episode Three

Carolyn McMakin and Kim Pittis

**this transcription is computer generated*
Kim: [00:00:03] Hello.

Carol: [00:00:05] Oh, hello.

Kim: [00:00:07] Hey, how are you? I'm great. I love Wednesdays.

Carol: [00:00:13] I do too. This is getting to be my favorite day, right?

Kim: [00:00:17] It's right in the middle of the week. So much has happened. We're not too tired yet from the end of the week.

Carol: [00:00:24] Hmm. Yeah, it's a perfect time.

Kim: [00:00:28] It is a perfect time. I have so much to talk about today.

Carol: [00:00:31] Oh, goody,

Kim: [00:00:32] I have like two pages of ideas and lists and topics and questions, and we're going to have to just pace ourselves.

Carol: [00:00:40] Ok. Works for me.

Kim: [00:00:42] Yay. The clinic looks fantastic.

Carol: [00:00:45] It's amazing. It's amazing. We have. We have H-back. We have wires. We have braces for desks. I ordered 5. And then you can. Ok. Or put it off to the side. I ordered 5 leather rocking chairs, glider recliners, nice for each room and one for the gym, and just ordered stainless steel carts with drawers to put all the machines and the gear in. Yep. And it's like, Oh my gosh, now there's electronic medical records. I have to get that, and then I have to redo my intake form because mine only lists male and

female. And now you have to ask a whole bunch of other things different, just different boxes. It's like so much simpler.

Kim: [00:01:49] I know.

Carol: [00:01:51] I know. Yeah, I'm really excited.

Kim: [00:01:54] Yeah. Yeah. So you have to keep posting the progress on Facebook because it reminds me of when I lived in Canada and we were waiting for this baby giraffe to be born. And they had like a camera on the giraffe all the time. We're waiting for this baby. So I feel like the pictures are like the baby and we're watching the baby grow and be born and and all the things.

Carol: [00:02:17] Wait till there's dry wall and paint.

Kim: [00:02:20] Ooh, that's so exciting. So yeah, you have to keep it on Facebook. Ok, so let's just jump right into some stuff. Ok. It dawned on me when I was listening to the podcast back, and as I've been talking about it to patients and to therapists, people keep asking, Is this for medical people to listen to? Or is it for patients to listen to?

Carol: [00:02:45] And the answer is yes.

Kim: [00:02:49] And that's what I said. This kind of reminds me of kind of like the resonance effect. You know, it was a book for practitioners. It was a book for the layperson to understand and read. So I wanted to make our theme today

Carol: [00:03:08] A little duel, a little

Kim: [00:03:10] Practitioner, a little patient based. And I wanted to start with one of the most reoccurring questions that I get when I teach the sports course and just kind of what I hear when we're at the advanced and like, you can just walk around and you hear like the the flutter and the and I don't even know if you'll be, we'll be able to answer this. But have you been able to condense what we do with FSM in a elevator intro? 30 second blurb.

Carol: [00:03:49] In this sense, yes. Ok. The thing I say is. Well, what a practitioner would say is I use a treatment, I developed a treatment for nerve and muscle pain using frequencies that I resurrected from the 1920s. So a practitioner would say I use a treatment called FSM that uses frequencies that were resurrected from the 1920s. That takes about 15 seconds to say. Mm hmm. And I never, ever has anybody not said. What was how did that happen? What for? And then then we take it wherever, and if they don't respond, then OK. But most people are totally intrigued. Yeah. So when we went to buy the leather chairs, the recliners, we're sitting down to do the paperwork and the man said, Why are you buying all these recliners for clinic? What kind of clinic do you have? And I said, Well, I'm a chiropractor, and I developed this treatment for treating nerve and muscle pain. Using frequencies that were developed in the 1920s. And we use them with a Microcurrent machine instead of the stuff that used back then, and he said. Really? What sort of things do you treat? And I said, well, nerve pain sort of easy and well, lately we just do a webinar yesterday on the Vagus nerve and on because it's so good at reducing inflammation, we can treat asthma, irritable bowel and he he jumped from. Have you ever heard of Eosinophilic Esophagitis? And I said, Well, yeah, that's kind of easy. And he almost cried.

Carol: [00:05:55] Yeah, his wife has. Well, he didn't say that she has a connective tissue disease. He says she has eosinophilic esophagitis and it's like, Well, that's we can treat that directly, but there's usually something behind that. Has anybody ever tested her for gluten sensitivity? No. Does she sprain her ankle a lot? Oh, yeah, all the time. Six or eight, maybe 10 times in the 30 years we've been married. And any of the kids hyper mobile, and he said, well, our son was almost diagnosed with more fans. What stopped them? I don't know. There was one step they didn't tell us. It's like, well, hyper mobility is passed down from through the females. And if you have a son, that's more fans, that money that you and your your wife and your daughter will be able to put their thumb on their forearm anyway, that was that was the progression. And it's like hyper mobility. We can trade. We can treat the Vagus. Yeah. So you start with we use frequencies that were developed in the 1920s with the Microcurrent machine to treat nerve and muscle pain. Once you say nerve and muscle pain. The whoever you're talking to, whether it's a practitioner or a patient, whoever you're talking to takes the jump into their own life, right? Can you treat low back pain? Oh, microphone, it's not funny. We can hear you, but I think it'll be better. Okay. She seems louder than you. Okay, Kevin,

Kim: [00:07:50] I have a fancy microphone.

Carol: [00:07:52] I know I see your microphone. I have microphone envy. There you go. Is that better? It's not plugged in, you know? It probably works better when I SportsCare.

Kim: [00:08:03] We're going to look back on these first few podcasts and we're going to be like, Oh, we were so cute. Look at us trying so hard.

Carol: [00:08:08] Yeah, right? Look at us trying to figure out the tech anyway. So that's that's the elevator. You start with nerve and muscle pain because nerve pain is impossible to treat from a medical perspective, right? Muscle pain is said to be psychological because. It's so difficult to treat myofascial trigger points are hard to treat. No, no, no, they're not. And. It just just the things that we know, because we've taken the core. Or watch the webinars. Everybody that keeps up with FSM knows about the Vagus nerve, knows about Vestibular injuries, knows about brain injuries, knows about SIBO gastroparesis. Liver disease. I mean, think nerve pain. Phantom limb pain. Mm-hmm. About all the things that you know. Because you do FSM, just the things, you know, you're right.

Kim: [00:09:22] And then that spirals into everything that you don't know.

Carol: [00:09:26] Yeah, so so when this guy said so that's that's a patient. Once you say treat, nerve and muscle pain, then they make the leap, right?

Kim: [00:09:35] And so and so let's just say you have a new patient and they know a little bit about what you do and they're coming to see you for some chronic low back pain, something really nice and easy that nobody else has been able to fix. And they say, So I hear you use a machine and you do some things with it. So what is it, really? And you can tell they really don't want to know like the full details, but they want a snippet of what FSM really is. How do you answer that part?

Carol: [00:10:05] So if they ask it that way, it's the same, the same rap, we use frequencies, I use FSM that machine over there. We use frequencies that were

developed in nineteen twenty. No, we use frequencies that I got from an osteopath who bought a practice in nineteen forty six that came with a machine that was built in nineteen twenty. And we use those frequencies with that machine and the frequencies appear to do exactly what they were described as doing on this list. The way it works, we're not really sure, but. If you think about it, drugs work by landing on a receptor on the cells and changing how the cells work well, FSM works. The what your key fob works when it opened your car door. It's the same principle, it changes the way the cells work by changing signaling. So that's a patient's version.

Kim: [00:11:14] So I think that's I think that's fantastic. It gives them, you know, enough information for anybody, regardless of their medical background to understand. We understand what our cells do. And I think using that helps them when they are expecting a TENS machine on them. That's probably the biggest thing that I get is they're like, I don't feel it. Can you turn it up?

Carol: [00:11:36] No, you shouldn't feel it.

Kim: [00:11:38] Yeah, and I'm like, do you feel your cells moving around in your body like, no, I'm like, then you won't feel this.

Carol: [00:11:45] That's a good answer. I like that.

Kim: [00:11:48] You remember, I work with these, like two hundred pound athletes who are expecting me to electrocute them when they come to see me and they want to feel something. So a lot, a lot of the times now I understand why there's a volume button on the PrecisionCare is I just turn the volume up. And then I'm like, I'm like, I'm like, Oh, does this, does this change anything? Oh yeah, I totally feel it now. I'm like. Ok. Glad it works now, you know, so yeah, I think it's hard for a lot of patients sometimes to to grasp, but they're not going to feel electrocuted. They're not going to feel the current. And then, you know, throughout the years of me practicing with it, I've sort of changed it and said, you might not feel it on your leg, but you might just start feeling it in your face. You might feel more relaxed. And as soon as I shift the focus from their leg or their back to their face, you can just see them like. Oh, yeah, OK. All right, it's like you don't have to try to focus on feeling anything like it's

Carol: [00:12:56] It's not going to take the pain away right away, but usually I wait until their blink rate slows down. Right, right. So if you're any place near the ballpark, the first thing that happens is their blink rate slows down and the respiration slows down just a bit. They're not stoned yet, but they're feeling something, but they're still hurt. Yes. So it's OK. The pain in your knee is this isn't like a TENS machine. The pain in your knee isn't going to go away. That way will reduce the inflammation in the knee. But you know how you're starting to feel more relaxed when we do something that relieves the dysfunction in the tissue we're treating. Then the whole system. Doesn't have to work so hard. Everything relaxes.

Kim: [00:13:56] Well, that's a that's a great way of explaining it. Yes.

Carol: [00:14:00] Thank you, Jim Oshman.

Kim: [00:14:02] Yeah, just that. Repeat that for a second. The whole system doesn't have to work so hard. That is huge. That's a big it's a big nugget.

Carol: [00:14:12] Well, if you think about when you when your knee hurts, everything tightens up.

Kim: [00:14:17] Totally. I was just going to say that completely describes splinting. Mm hmm. Right.

Carol: [00:14:23] Know when the knee starts to get better. Everything, but I wait until the blink rate slows down because usually they're still waiting for something to happen at that point. Right? Watch their face. You can. You can see it happening, right? Yes. Yeah, it's the blink rate. But you may have your own intel.

Kim: [00:14:47] You know, a lot of times my. I see a lot of like nervous, edgy, you like athletes come in there, they're wound up their go, go, go, go, go. So I'll find that, yeah, the blink rate. But before the blink rate slows the.

Carol: [00:15:05] Look.

Kim: [00:15:08] Oh, are we back? We're back, so yeah, before that, the blink rate, like the fidgeting to me, seems to to stop. So it's the same thing, right? That'll happen before the blink rate. They start like picking, they start fidgeting. Com blank breathing. And then before you know it, they're asleep. And I'm like, Hey, wake up my four o'clock patients here. You have to

Carol: [00:15:30] Leave.

Kim: [00:15:32] You don't have to go home, but you can't stay here. It's what I. It's my next sign that I'm going to put on the clinic wall

Carol: [00:15:38] And hence why we have recliners. Yeah, you can go to the gym and just sit in the recliner for a few minutes. So the quarter is going to have a gym, we hope, and a pit that will do proper sort of rehab exercises with them.

Kim: [00:15:58] Are going on this wave that we're on just really quick. So if you so these are for the practitioners now listening, should you have a patient that is quite. Floaty after a treatment, and you're going to put them in the recliner, what are your go to frequencies to help float?

Carol: [00:16:20] Oh, six point eight and thirty eight AST. 9 and ninety. So it's usually six point eight and thirty eight brings him around and something under a minute. And if that doesn't work, I'll use forty nine and ninety to wake up their cortex. It's like, Hello.

Kim: [00:16:41] Do you ever use thirty five and one hundred two?

Carol: [00:16:45] You can do that. Some, some people that make some more stoned. Right? Six point eight and thirty eight tends to be just grounding. Correct. Yeah, that's that's my go to when they when they won't wake up, right? And I don't I don't fuss at them to wake up because they can hear you. They just don't want to open their eyes, right? Yeah, it's there's it's just like aggravating them.

Kim: [00:17:12] Have you ever had anybody that doesn't like that floaty feeling?

Carol: [00:17:15] Oh, yeah,

Kim: [00:17:16] Oh yeah, yeah, yeah. We run that kind of

Carol: [00:17:19] Well, know what happens is if they. If they get. They get agitated, so they get floaty and then they get vigilant. And so that's the point at which I say, you know, the floaty feeling your feet you had. I'm. It's been so long since I've had anybody that minded it, you know, that floaty feeling you had, that's normal. It's completely normal and it usually happens in people, two kinds of people, either people who've never touched alcohol. And never touch drugs or people who have a history with alcohol and drugs. The feeling of being floaty is like, Oh my God, I'm relapsing. This is right. This the last time I ended up getting arrested or getting in trouble, it was this feeling right either way. They start to relax and get floaty. Then they get vigilant, agitated, and I'll say so. The floaty feeling is normal. So that's the first thing. It's like it's normal. It is also very temporary. So we don't charge extra for it. It's legal in all 50 states. So I've been using that. Yeah. And and by the time you leave the clinic, it will have worn off. You'll sleep better tonight, but. I will make sure that you're usually wears off by the time you leave the clinic and we'll make sure you're okay to drive before you leave. And then as long as they know it's normal because I don't warn them that they're going to feel floaty because what if they don't right?

Kim: [00:19:13] And then they're expecting it and they think the treatment is a failure because they don't feel like that, right?

Carol: [00:19:19] So once they start, once the blink rate slows down, it's like, OK, you know, the floaty thing that's happening now. Yeah. Well, what is that? Oh, well, it's just what happens to virtually everybody when the treatment is correct for what you have, the endorphins go up. We have that data. And people just start feeling floating and it's temporary. It's legal in all 50 states. We don't charge extra for it, just part of the Cervicis. So that's how I handle it. How do you?

Kim: [00:19:57] Yeah. Very similar. In the athletic community, it's funny. I'll get a call. Hi, I'm so-and-so from this team. I'm like, Hi so-and-so referred me like, OK, I heard, I heard, like, you can make people pass out. They'll be like this.

Carol: [00:20:13] They think.

Kim: [00:20:15] Like, not always. You know, and then they do they come in expecting it because I feel like the vast majority of athletes get quite stoned very quickly. And, you know, I'm trying I'm trying to figure out like, why is it, you know, my continual questioning are like, why do athletes love being polarized positive? Why do athletes get stoned so fast? You know, part of it, I think, is just that stress level, right? And they're so used to getting those endorphins and in Kaufland like that fluctuation.

Carol: [00:20:50] So they're so constantly stressed, right? Totally. Yeah. So as soon as you relieve the strain in their body, then it's like, Oh, I can relax and they're gone.

Kim: [00:21:08] Yeah, it's it's really interesting. And what's even more interesting is my theme today that I wrote down that I wanted to circumnavigate a little bit is taking a very organic trip down that road anyways, is the emotional frequencies and some of the emotional stuff that happens when we work with patients because I feel like I've told this story so many times at the advanced lectures and in the sports course when we teach the emotional frequencies and I'm the first one to admit when I'm wrong, it's for the first two years a year and a half, at least a solid 18 months. I did not use the emotional frequencies. It didn't make sense to me. I couldn't measure it. There was no smush, there was no range of motion. There was no like. Objective measure that I figured out that I needed it, it just seemed to. It did. Yeah. I love scar tissue. I love inflammation. Like, give me all that stuff, you know? But sad and angry and fear and grief. It just wasn't something in my forebrain at that time until I had to use it with an athlete. And and I'm pretty sure you do still tell the story about the little bird on your shoulder that talks at you when you're treating somebody.

Kim: [00:22:37] And it was somebody had restricted hip flexion whose glute max all the hip extenders were not letting go. It's been three days of treatment at my wit's end literally went through every single frequency on the fricking luminance. And he's lying supine on the table, and I'm cranking his hip into flexion and nothing is giving, and he keeps talking about how frustrated he is with this injury. I'm like, Yeah, I know, do shut up. Like, This is taking forever. I'm so frustrated. I know. Trust me, I'm frustrated, too. Yeah, no. I'm getting kind of angry. I'm pissed off, too. Like Buddy. Like, we're on the same page here, and he's using these words that he hasn't used before. Frustrated. So I came at how scared he is about losing his job and losing a spot on the lineup. The

team is winning without him. You know, how dare they resentment all these things? And I'm just like, OK, that's like six emotions that he just like laid out in front of me. What if I just put on the emotional frequencies and I kept him in hip flexion? I needed a measure. I didn't believe it still. And so this was after three days of treatment. And I just changed it to 9 70, and something started

Carol: [00:23:56] With seven fear.

Kim: [00:23:57] Yeah, I was gonna say, I think I started with fear first. And he's like, Dude, what are you pressing right now? And I'm like, Why? Oh, did you feel like it feels like it's something it's giving? And no sooner did he say that, like his hip went from here to like, I almost like, fell on it. Oh, that's amazing. I took my hands off and I'm like, I'm just going to need a second left the room, I was like, Whoa, what just happened there? Because I objectively measured fear and anger with range of motion and. And I was like, OK. Took a deep breath like compose myself, came in, pretended like I had planned the whole thing all along. Totally owned it. I'm like, OK, let's just run a couple of these things and kind of went through the gamut of all of it, even like grief and things like that, because resentment. He was, you know, all the things started coming out, of course, ending it with restored joy. He jumps up. He's like, Well, that was fantastic. I'm like, Yeah, it was just a minute. While I call everybody that I've seen in the past 18 months and have them come back in because that's it. So there was that component. So that was what changed my life with the emotional frequencies. And I think now that. You know, I've been practicing with them, sometimes I'm still unsure of when to run them. You know, do we run it before we actually start working with the soft tissue stuff? Do we run it and I use this term, I run some of them. Sometimes I run them in the background, so I'll put some of them on a CustomCare when I know something is indicated. So if there was a motor vehicle accident with some trauma or loss or grief or whatever, or maybe you just have that. I don't know that person that just has a lot of emotion to it, do you run it at the same time? Do you run it before? Do you run it after? What's your

Carol: [00:26:08] Oh to? In the background. So if I'm working on a neck and shoulder or a low back and leg or whatever, I'll run concussion and Vagus on. Just back to Abram's on a separate machine. Yeah, because my biggest shift in the last five years with the emotions is the emotions are a result of the brain and the endocrine system. So you can

treat anger and fear and the emotional frequencies work, but it's a lot like where are those emotions created there in the amygdala and the hippocampus and the insula there in the mid brain? So it's almost like now these days, now I'll treat 40 and 89 to sort of take the pressure off the emotion. Hmm. Then you followed that with 40 and ninety four to quiet down the reticular activating system. And you can do all that by running the standard concussion in Vagus while you're doing everything else, right?

Kim: [00:27:21] Right?

Carol: [00:27:23] I had one patient ask me. What's the frequency for? Killed. I just feel guilty about whatever I said, well, that question has come up literally for twenty five years. And there isn't a frequency for guilt. But if you look at how guilt works, it's not really guilt. You're angry with yourself. You're angry with yourself. So I run 9 70 and thirty five. And resentment. So anger isn't always directed at somebody else. I wonder if guilt isn't self judgment and effectively you're angry at yourself. You resent yourself because you did this stupid or thoughtless or difficult thing. Almost always anger. Resentment. Twenty seven terror. It's kind of in that order. And then maybe grief, because if you treat the only time I've ever gotten in trouble with the 9 70s was treating grief first.

Kim: [00:28:47] Ok, because

Carol: [00:28:50] All like the chronically ill patients. That you see they. They feel grief for what they've lost. So you get rid of the pain first. And that's when they find out they can be pain free. Right at that point. If you have the time to run it, it's a really good idea to run at least anger because the first reaction? Before they get to experience, grief is. Anger up to rage at the twenty seven doctors who told them it was all in their head drugged them insensible didn't help them or actually hurt them, right? So you deal with the anger and with anger always comes resentment. So 970 and thirty five and 970 and thirty eight, it's a different way of thinking about how emotions are stacked. And so they get angry first. And once they deal with the anger. Then the grief comes great, they have to get they get rid of the anger that they have to deal with the anger first.

Kim: [00:30:14] Many moons ago, I went to pain conference in Canada and there is a psychologist that was there talking about chronic pain patients, how they process it. It

had a big thing to do with motor vehicle accidents. So kind of going on what you were talking about. However, she said the first emotion is fear that anger is always secondary to fear. Makes sense when you think about road rage, right? Someone cuts you off. You honk your heart. And why are you screaming at them? Because you were just really scared that they were going to kill you? So I was I think about that a lot. When I'm treating patients who are angry, is they scared?

Carol: [00:30:56] Yes, that's in the more acute phase. So first, if an auto accident patient that comes in even two or three months after the accident, it's more than the acute phase. They're still living with the terror of the injury itself and the fear that I might not ever get better because I've been three months and these four people couldn't help me. And what if I don't get better? And what if? What if so, fear is usually in the early stage after they've been in pain for 10 years. They're not afraid anymore. They're just exhausted and hopeless and desperate. And it's not until. You get them out of pain, so a 40 and 10 patient or a phantom limb patient or, you know, the kinds of things, even a nerve pain patient. You get the pain in 20, 30, 60 minutes. And their reaction internally is. Yeah, yeah. What on Earth? Why? Why is it that the last I've seen 12 doctors? And three of them told me it was all in my head, and that's so they're pain free, they're happy about that. They're confused. Their brain is trying to download new software, right? The campus says, Yeah, you're out of pain, but there might still be a tiger.

Carol: [00:32:35] So let's not relax and enjoy this yet. So it's it's this jumble. It's it's that thing we were talking about that we'll have to talk about at some point. Yeah, something I wrote, but it's like it's this jumble of reprograming. Their entire nervous system. And then you have to tell them it's probably not going to last. Two days is the last any place between two hours and two weeks. It's going to come back, but when it comes back, it will be different and it probably will not be as bad as it was before. But you're going to mind it more. So that's the thing that we get to address. I don't know anybody else in the world that addresses the two parts of pain, right? It actually hurts. And how much you mind it? You have the functional medicine scores like Oswestry and TAOS and whatever. That's functional, but there really are two parts of pain. Once it hurts, how much you mind it. So when it comes back, it's it's not going to be a seven or an eight. It'll come back at a five or six, but it's going to piss you off.

Kim: [00:33:58] Mm hmm.

Carol: [00:33:59] You mind it more because it's been gone and now it's back, and then it gets scared right when. So it's not till the third visit that they believe that's actually going to last. And I'm talking about more about the chronic pain patients.

Kim: [00:34:16] Right, right. I this reminds me a lot of the early days when I was working in Canada and we had a lot of chronic pain motor vehicle accident patients coming in. And I was so part of that FSM learning curve, that roller coaster like I was on the top. I was fixing everybody, like, give me all the people and I had a gentleman that had a horrible collision. I think it was about eight or nine years ago, and he had some chronic neck post-concussion stuff that we cleared up in 3 treatments. And he was great and sending flowers, and I got lunch coupons sent to the office and life was good until he came back about two weeks after he was mad. But raging, I'm like, what happened, what's wrong, he's like, I lost eight years of my life. And that was something I wasn't really prepared for, I was prepared for extra range of motion, increased strength, you name it. I was like ready for those type of changes. I was not ready for I lost so much. And now what do I do? What do I do now with the memories? The the eight years that I was on disability and like, I got that one OK,

Carol: [00:35:42] Because it's the only way because that rather than athletes, that patient population has been my whole group. Yeah. The only way I can keep my sanity and what I tell them is the only way I can make sense of this is that. Everything that comes into your life. Has a gift for you, has a lesson for you. That makes you a better person. So you lost a lot in the last eight years, but what did you learn? What what what did you learn, what did you get? And they go, What do you mean? What did I get? It's like, Well, OK, you haven't been able to mow the lawn for eight years and you found out that the world didn't come to an end. Oh, you learned empathy. You look at people on crutches differently than you did eight years ago, right? Oh yeah, right? And you found out that people will help you, you learned compassion. And it's it's going to be different for every patient because it's, you know, it's a personal sort of awareness, but you have to get I think it helps to get them to shift the perception. It's like now if. We're lucky. You get to get rid of the pain, but you keep all the wisdom. You have keep that you're not the same person you were eight years ago. You have to rebuild your life, find out who you are now, what you can do now. But you're different and I think my personal thing is probably better. Right, do you have more compassion for yourself? You had to be

kinder to yourself because you couldn't do the things you were used to doing. Right? The world did not come to an end. Right, right. You found out that people would help you. If I'm right, you yes.

Kim: [00:37:57] Yeah. There's a framing it.

Carol: [00:38:00] Yeah, I think that's the only way to do that. But yes, that is a really common. It's.

Kim: [00:38:07] Yeah, there a there's a lot that

Carol: [00:38:11] Twice a week for four to six weeks and the last two weeks like they're out of pain at the end of two weeks most of the time or 3, the last one or two visits are to clean up that sort of thing. The emotional stuff, the strengthening how are you doing with activities?

Kim: [00:38:30] That's right. I think the I just love how I write these notes down about to keep us on track and we just know this. This one has been great, actually. It's kind of like hitting all my talking points that I wanted to get at. There's there was what? You know, we keep teasing the audience here about this thing that you wrote, this thing that we have to talk about. And that's the thing, but there's a lot that for the practitioners that are listening that are new to this and even to people who have been practicing for a long time with it, I think we have to prepare ourselves sometimes for these unexpected. We think with our forebrain, we're so cerebral and we're treating patients, but there is so much more that we're changing and affecting that there is nothing else in the world that I've come across in. My time here practicing that is remotely close to the changes that we create with our patients and then with us as practitioners, and I think that I didn't I was not prepared for how much better I would become because of these patients that were coming into the clinic. I am treating people I would have never dreamed of treating or going there to have to treat. So it makes you better because. And we always say, Oh, this is easy. Oh, OK, you know, it's easy. Why? Because we're at the far corners of our brains, you know, reaching and grabbing. And so my next kind of question for you is, who do you think make the best FSM practitioners like? What qualities if I were to say build? A, how would you build a successful FSM practitioner and I don't mean like, what kind of credentials they need? There's a certain. Stock qualities.

Carol: [00:40:47] Yeah, I that's a that's a hard question because. The the thing that we do that's so different than I think any other. Technology that's out there is we're able to change so much, so fast. So that chapter in the resonance effect, believe what you see. Right, that. So. It doesn't matter what your medical credentials are. It's. The ability to synthesize information from different areas, so we have physical therapists. And manual therapists like you who are. Who have frequencies for and training in how to recognize Vestibular injuries. What would make you look for that? Well, you have all those questions, and it's a patient who is a systems engineer that gives you a completely tangential, disorganized history. So we have a really comprehensive. Education. Right? So the ability to synthesize, even though my training is as a medical physician, a neurologist, a psychiatrist, a physical therapist, a massage therapist, physical therapist. You have to be able to synthesize information from different parts of the course so that you can use the frequencies because we're not just treating his knee. There's no way to treat the knee without treating the brain, the spinal cord sensitization, the central sensitization. The torn and broken and the tendon, we have to think of things that nobody else has to think of, right? There's no there's nobody that can fix a partial thickness tendon apathy in 40 minutes. There's there's no there's nobody else that can do that as far as I know.

Carol: [00:43:06] Even the pro therapy. First, you have to make them hurt and then then you make them hurt again. And then in six weeks, it's supposed to be better. And with us, it's 60 Minutes synthesis and. Observation. People that are very keen observers. That. Pay attention to what's under their hands. The person that's on the table. Um. Observers, synthesizers. And there's something in there about sensitivity. Right. So sensitivity to Smush or some indicator? So, Roger Velika. Brilliant, right. Medical physician, medical director of NASA Functional Medicine and how does he decide that a frequency is correct? It feels for Smush. Right? Ok, that was a surprise. So that and the sensitivity some people feel for warmth. Some people feel for the change in their own field, right? So that degree of sensitivity and I have a physical therapist who's never took the FSM course like 15 years ago, and she's working on me for my stuff and she. Let's say we treat scarring in the nerve. And she gets stoned before I don't get stoned anymore. It's like. But she gets totally, she said, How do you do this? And I said, Well, you get used to working stoned. Just go. So flexibility. Right?

Yeah. So since it's the ability to synthesize, to be an observer, to be sensitive and this last one. I don't know being able to work flexible

Kim: [00:45:21] Disability, I was going to say adaptability, but same thing. Yeah, something like that.

Carol: [00:45:27] So you don't get stuck on your ideas just because it's this and the frequency doesn't work, then that's not what it is. So.

Kim: [00:45:38] Right, that kind of circles back to what we talked about last time is like, don't stop looking. If it doesn't make sense, don't. The don't that can't be OK with you.

Carol: [00:45:52] It. Yeah. That's exactly it. And Roger, Dr. Belikov said in one of his lectures, he tells his patients, I won't give up on you if you don't give up on me. We may not fix it. Yeah, we may not fix this as fast as we want to. But I won't give up on you if you don't give up on me and you and I form a team. To get you better. Yes, and that

Kim: [00:46:24] That's a really important piece, I think, to keep reminding patients I had two patients this morning that we're kind of in the same boat came in lots of pain, lots of dysfunction and we made some good progress. But now we are at a very dangerous portion of the treatment where if we take away too much without giving them the good stuff again, this is Dr. Blix's analogy, and we do this with scar tissue a lot. If I can't catch up their strength in time or at least tape them and brace them to give them some support. We're at a dangerous crossroads, and we talk about when, when you make patients worse happened all the time. In the early days with the shoulder, I would unravel scar tissue that was keeping a torn labrum from doing its thing. And you do. You go way too fast and then you're reaping the fallout. So I think that's important with patients who are like, you get them better, so much faster and then they want to just go from like you got them from a 10 out of 10 down to a four. And now it's like losing that last five pounds like they want to be out of pain, out of pain. You're like, OK, well, we there's a process. So that's a great analogy that. Don't give up on each other, you got to work together, and there is that balance right of, especially when it comes to chronic injuries, I think is what we do works so well and so fast that I think sometimes we as practitioners are not ready for the changes that we're going to see.

Carol: [00:48:12] I had a practitioner tell me. In an email, he said, You prepared me for the failures. You you told us during the class you prepared me for the failures. You did not prepare me for what I've done in the last two weeks. You didn't prepare me for the successes. How did I just do what I've done in the last five days with these patients? Right? And it's just it's almost overwhelming.

Kim: [00:48:49] Totally.

Carol: [00:48:50] And you learn these days have learned to tell people at the end of the seminar, it's like now you have the basic information after five days. Everything else you need to know, the frequencies are going to teach you. And I'm not sure they understand how comprehensive and true that is. So you learn over time. There will always be mistakes. You're always going to. That's how you learn. It's one hundred percent. So when you take apart the scar tissue in somebody's shoulder. And I've learned to tell them these muscles have been tied up in knots for five years. They haven't exercised in order to be strong, you have to relax and contract and relax and contract and relax and contract. If all you can do is contract the track. The muscles week, it's been tight, but it's weak. So just because it doesn't hurt doesn't mean it's strong, right? So and this is the conversation I have with weekend warriors and especially male humans. No offense, but when you go back to the gym. If you're used to 50 pounds, you take it down to 10 and they look at you like your green.

Carol: [00:50:25] Yeah, it's like if you tear this, it's going to be your own fault. This week it's been inhibited. You have to strengthen it carefully or we're going to end up having to do this all over again. Mm hmm. And you make eye contact because then they're in a state of hypnosis and you go, Do you hear me? I was like, Yes, ma'am. And then it's like, it's going to strengthen much faster than you think it will. Yeah, but you learn that as you go along, there's no way to teach that in a five day course. That's why we have webinars. That's why we have this broadcast. That's why we have the sports course. That's why we have the advanced and all the case reports. I'm really excited about this year's advanced. I decided to bite the bullet and make it a three day so that we get case reports. Oh my gosh. And on Sunday, which is the case report day, yep, have a two hour lecture on the endocrine aspects of traumatic brain injuries.

Kim: [00:51:36] Oh, I think you're saying that.

Carol: [00:51:38] Oh my gosh, I was a fool as

Kim: [00:51:40] A physician from Reno.

Carol: [00:51:42] Yeah, I'm AST. You pass awesome and then fill up the day with case reports. So everybody that's listening. Start thinking it's only 20 slides, you know, take a Valium or a something,

Kim: [00:52:00] And the audience is so supportive and kind.

Carol: [00:52:03] Oh yeah. Well, because everybody's been there, right? Yeah. Even though it's something that you take for granted, Oh, I treat this all the time. There's going to be somebody in the audience that's never seen what it is you have to present. So to me, the the advanced material is what it is. The advanced faculty is great, but the case reports are what make the symposium so special. And I decided, well, the advance needs to be special to yeah. The advance is going to have case reports. So the fifty three of you that are signed up and everybody that listens to this, they're going to get an email asking for. To reserve a slot perfect GGT report

Kim: [00:52:45] Before we run out of time, I think we need to address the two questions that I see popped up here. What areas would be your placement for severe edema in lower leg, foot and thigh? What would your treatment protocol be?

Carol: [00:53:01] Karen, that goes back to what caused it. Why does somebody have severe edema in the lower leg, foot and thigh? And the way you said leg means one leg. So the first thing you do is. Get an ultrasound of the leg. And if you can't order one, you send the patient back to the physician. Their GP with a note that says this patient has unilateral severe lower leg, foot and thigh edema. I am. What's the best way to put it? I'm reluctant that's a good word. I'm reluctant to treat them with conservative means until I'm sure there is not a deep vein thrombosis. Um, and you're presenting the physician with the diagnosis. What has to be ruled out? Um, without busting him for not figuring it out in the first place, you're saying, you know, more so much more than I do about this sort of thing, I'm reluctant to treat this patient with conservative means until I'm sure it's not a DVT. If you can order blood, work your cell yourself. You can order a

D-dimer, but it's really expensive and an ultrasound is really cheap, so you send them in for imaging, you get an ultrasound and the last person I saw with unilateral. One leg Idema had. Dvt that completely occluded, the tibial and fibular vein systems in the lower leg and almost occluded the femoral vein from the groin to the knee. Right. And it's like, I'm not touching it. So. If it's one legged. The only other thing is what caused it, so if it was caused after a vein stripping? Well, the the laser that they use in the vein stripping heats up the vein and that causes scarring in the. Lymphatic, which are right next to the main TENS Endolymphatic just collapsed and there's fibrosis in the lymphatic. So you go back to. What caused it?

Kim: [00:55:46] She writes here there is no DVT. That's what it is, but no DVT. She's saying so again, why is it?

Carol: [00:55:56] Yeah, figuring out because they did an ultrasound.

Kim: [00:56:00] Doesn't say here, she just writes, there's no DVT.

Carol: [00:56:03] Ok, well, then I'd go, I'd look at fibrosis endolymphatic, LOX and up in the groin. Yeah. And. And see what happens.

Kim: [00:56:17] Yeah. Let's go back really quick to the other questions here. Any thought about using constitutional powers with emotional powers? Also advance list shows guilt resentment stubborn as 9 70 9

Carol: [00:56:32] 3 should be 9

Kim: [00:56:34] 70 970 3

Carol: [00:56:36] 38. That's the we put guilt there because people kept saying What's the frequency for guilt, right? Somebody said, Well, it's resentment and sort of a passive aggressive kind of anger, but I never run 38 by itself without 30 5. So and leaf is used to the frequencies he knew Harry. So the constitutional pairs leave. I don't use the constitutional pairs so much as I use the brain parts. Forty and eighty nine, forty and ninety four to quiet down the CNS. That gives the intensity to be. Emotion, right, LOX and balance for a toddler had the complete opposite effect wide awake. I, you know,

kids have paradoxical effects. To antihistamines, make him hyperactive, so I don't I don't know. I know when, when you're treating a nerve. So when we're at the Cleveland Clinic and I'm treating this kid with a nerve traction injury as herb's palsy, long thoracic traction, injury, brachial plexus traction, injury, you run 40 and 3 9 six and the kids blink. It slows down and they're still moving, but they're there. You know when the kid is fighting the nap?

Kim: [00:58:13] Yeah.

Carol: [00:58:15] And then sometimes you just go fall asleep on the floor. So, no, I don't know enough about that. I don't treat enough children. Hmm. Thank you, Ivor. I appreciate it. Yeah. I've learned how to communicate with MDS just. I lived in their world as a pharmaceutical rep for 16 years, and these days there it's a different world. They have seven minutes and we have 60, so but they have the authority to prescribe and to order things based on the insurance that the patient has. So you have to be respectful of their position and. It's important not to interfere with the patient's relationship, with their medical, for their primary care provider. You're you're you're an. Intervening in that relationship and it needs to be smooth. So you have to be respectful.

Kim: [00:59:29] Ok, and then two more questions in our little time period best treatment protocol for arm and leg neuropathy post chemo for breast cancer.

Carol: [00:59:41] What? Arm and leg neuropathy. Mm hmm. Uh, if they used cisplatin, which is not usually used for breast cancer, I don't get that. Some arm and leg neuropathy, the there's a. Neuropathic pain with peripheral neuropathy with toxicity. Right. That's in the that's in the core. So you just add the frequencies for toxicity. The thing I would look at with breast cancer, if it's just chemo, then you just have to hope it's one of the Chemo's that responds to. Fsm, so cisplatin, not so good, the other ones, we have some success in, if they used radiation. That's where you get into trouble, because the radiation. Doesn't just hit the breast. I mean, the sunburn, the the skin damage is superficial, but the x rays go all the way through and they form scar tissue and the blood supply to the spinal cord and the nerves. Right. So. I, if they used radiation, look at treating not just the chemotherapy, but the radiation frequencies and the scar tissue in the nerve and the blood vessels, OK?

Kim: [01:01:21] Any contraindications using scarring 39 or 50 eights anywhere in the body if patient had a sling surgery 10 years ago? No.

Carol: [01:01:32] When you're on the place where the ceiling was placed, you might want to be a little bit careful, like if it's a bladder ceiling or a pelvic floor ceiling, you can thin that out. You don't want to take it all away unless it's adhered to a nerve. And that's a problem. And if it's 10 years ago, the scar tissue should be really pretty solid, and I find that 13 takes away mostly the scar tissue that's dysfunctional, not the stuff that's necessary. Correct. And Ivor, Oh, thank you. I love it when you doxorubicin still is sometimes used for breast cancer can result in neuropathies. So I still try the peripheral neuropathy with chemo, right? And that. This is really fun.

Kim: [01:02:24] Yay! And we kept sort of on our theme, we got all through the emotional things that we that I wanted to touch on because I feel like it's neglected. Sometimes we get we talk so much about other things, and I feel like we all have emotions.

Carol: [01:02:42] Rather little things inconvenient, right?

Kim: [01:02:46] This is perfect. So everybody keep your questions coming. This is fantastic. Yeah. If you have any other announcements, you can shut them out now and we have a whole other week to prepare.

Carol: [01:03:06] I have to and I have to thank you for providing the questions, I'm great in floating down the stream wherever you, you send the stream afloat and I love it that you give it direction. It's just wonderful.

Kim: [01:03:23] It's just me and my my brain needing to keep the train on the track as much as possible. So yes, this concludes yet another wonderful Wednesday webinar. We have to come up with the name. I sent a podcast generator. It was so funny. You can Typekit your names in the days and we came up with some really funny ones. So until then, we'll just have our wonderful Wednesday webinar and

Carol: [01:03:53] Follow up, though, from Dana Pletcher over here in the Q&A. Ok, had COVID was in the hospital for eight days? No, he was in the hospital for seven and his wife was eight. The. Covid protocol was really helpful, the normal on with oxygen

saturation on room air. So Cheryl is normal. He's still on oxygen two four seven at two liters, but the new alveoli and bronchioles protocol is working. Oh, dear, oh. He said my issue is stupidity as a husband and a man, Cheryl knew I should go with the paramedics when she did, but being a guy, of course, I knew better and waited for days. That was hilarious. So Patterson was a chiropractor in Texas, and Chelsea and him were working on a professional golfer that wouldn't follow directions and got himself reinjured, you know, every month. And Patterson came up with, I think, a good closing phrase for today's webinar. Kay Patterson said, Chelsea, we don't have a frequency for stupid.

Kim: [01:05:24] Oh, I love it, that's wonderful. Not yet, anyways.

Carol: [01:05:28] Yeah. Goodbye there.

Kim: [01:05:31] All right. Have a great risk to your week and we'll see everybody next Wednesday.

Carol: [01:05:35] I'll see you next Wednesday. Bye.

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